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DATE NOTICE SENT TO ALL PARTIES: Dec/01/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left TF L5-S1 epidural injection lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. Is the opinion this reviewer the request for a left TF L5-S1 epidural injection lumbar spine is not medically necesary.

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a male. On 09/22/15, a MRI of the lumbar spine revealed at L5-S1 there was a 2.7mm broad based disc bulge, slightly asymmetric to left which did not displace the S1 nerve root or efface the thecal sac. There was no central canal or foraminal stenosis. On 10/14/15, x-rays of lumbar spine demonstrated no abnormal motion with flexion/extension. On 10/14/15, the patient was seen in clinic. He described low back pain as well as right buttock and posterior leg pain. He reported having 11 sessions of physical therapy since his injury and denied having epidural steroid injections. On physic exam, he was unable to perform a heel or toe walk due to pain and weakness. Right plantarflexion strength was rated at 4+ and strength elsewhere was rated at 5. Straight leg raise was positive on the right and negative on the left. Deep tendon reflexes were all rated at 2+ in the lower extremities. A transforaminal epidural steroid injection was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 10/22/15 a peer review report for the requested left TFL5S1 epidural steroid injection noted the request was not medically necessary as the patient reported right sided leg pain, and the MRI showed a left sided disc bulge without stenosis. There was no right sided disc herniation or stenosis and the exam did not match the imaging findings. The request was therefore non-certified.

On 10/27/15, a utilization review report for the requested left transforaminal epidural steroid injection at L5-S1 was considered not medically necessary.
On 10/28/15, a peer review report noted the request for a lumbar epidural steroid injection at L5-S1 was not medically necessary as the patient had low back pain and right leg pain, but the request was for left epidural steroid injection and all findings noted were right sided. Therefore the request was non-certified.

On 11/02/15, a utilization review letter noted the requested left TF LESI at L5-S1 on appeal was non-certified.

The guidelines indicate that the procedure may be considered reasonable and necessary if radiculopathy is documented on exam and corroborated by imaging studies and or electrodiagnostic studies. The MRI reveals at L5-S1 there is a disc bulge asymmetric to the left which does not displace the S1 nerve root or efface the thecal sac and there is no central or foraminal stenosis. The exam note of 10/14/15, notes the patient has a positive straight leg raise on the right and 4+ right plantarflexion weakness. Thus, the physical findings do not correlate with imaging studies.

It is the opinion of this reviewer the request for a left TF L5-S1 epidural injection lumbar spine is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)